MENTAL HEALTH SERVICES ACT (MHSA)
Stakeholders Meeting
December 17, 2004

Attachment 1 – Individual Feedback

Participants were asked to provide individual feedback on three questions. Not everyone responded. Below is a summary of their responses to the three questions, both qualitatively and quantitatively.

1. **Does the Draft Vision Statement (Attachment B) match the picture in your mind of what the MHSA should accomplish? If not, what corrections, additions, deletions or other changes would you make to the Vision Statement?**

Approximately 250 people provided responses to this question, many of them with multiple concerns, for a total of 388 responses.

Theme	#
Populations/Consumers and Family	49
Children	46
Alternative Treatments/Support Services	29
Integration with Primary Care	28
Workforce/Training	28
Cultural Competence	28
Outcomes/Quality of Life	25
Prevention and Early Intervention	24
Vision Statement Process Issues	24
Best Practices/Seamlessness/Transformation	17
Stakeholders/Collaboration/Criminal Justice	16
Substance Abuse/Co-Occurring Disorders	14
Other	110
Total	388

Themes

Below is a summary of the major themes, those which were drawn by 10% or more of the respondents.

Populations/Consumers and Family (49)
This area, not surprisingly, received many comments, but also covered a wide range of concerns. Respondents were concerned that consumers and family members be included in decision making and input; raised issues of family members in disputes with consumers; expressed concern about reaching the unserved. Several expressed concern that the definition of the target group be enlarged to include people above 200% of poverty, because mental illness can render people poor quickly and private health insurance does not always adequately cover mental illness. Reaching the homeless population (and ending homelessness entirely) was a concern of others. Reaching older adults and those locked up was important to others. People raised issues about DMH's understanding of the client culture, such that providing feedback in a large meeting is challenging to consumers.

Representative responses:

- The vision statement has been arbitrarily created without any input from consumers. Why are you running this ahead without waiting until counties can be informed and give their input after being informed? I suggest that the DMH is trying very hard to be fair but does not understand the client culture. We cannot process the same way non-consumers can.
- Need to address or integrate two principles: providing services with "already demonstrated effectiveness" and "funding expended in accordance with recommended best practices" with principle of "consumer and family participation and involvement in developing service plan." These two principles can work at odds if we don't explicitly include consumer and caregiver education and training in best practices in mental health.
- While the vision statement incorporates consumer and family involvement, the language of the state and MHSA still describes services to be provided as illustrated in AB 2034 and children's system of care. What is missing and highly recommended to be included are "family oriented" programs and services that take into account key head of household members' roles in culturally and linguistically competent service delivery

Children (46 responses)
Many people were particularly concerned about the needs of children, transition age youth and foster children. Some wanted more definition of the terms and ages considered for transition age youth, most of those seeking the widest age range possible (14-25 generally). Some were particularly concerned that foster youth were being squeezed for services and others were particularly concerned about the collaboration with schools.

Representative responses:

- Children's services mentioned, but not enough
- Regarding K-12 services: comprehensive services from outside providers need to be integrated with qualified credentialed PPS providers
- Page 3, bullet 4: "Live at home" – emphasis should be places on MHSA intent to prevent custody relinquishment when families cannot afford the mental health care required by their children. As to "specific strategies," this should specifically include (and should be mentioned in the vision statement) implementation of SB 1911 (Ortiz), which calls fort he development of a HCBS waiver for SED youth at risk of or in out-of-house placements. This would certainly be consistent with Page 2 of the statement, in which DMH states it will be guided by the principles and reviews of other source documents, including previous Little Hoover Commission (LHC) reports. LHC specifically recommends the type of waiver SB 1911 contemplated and would be consistent with the goals of preventing removal of SED youth from their homes and communities.

Alternative Treatments/Support Services (29)

This theme incorporates both the inclusion of alternative treatments and modalities and the strengthening of support services such as employment, training, money management, housing, transportation, in-home support, as well as using a holistic approach. The call for specifically including employment assistance was by far the largest group, followed by an emphasis on housing, including long-term, transitional and immediately following release from a hospital as well as board and care facilities.

Representative responses:

- Include alternative medicine
- Include language that includes a holistic approach to treating the whole person
- Add as a goal to eliminate the phenomenon of the homeless mentally ill

Integration with Primary Care (28)

Integration of mental health services, especially with primary care, but also with substance abuse and the criminal justice system to a lesser extent, was a common theme. Respondents believed that this was a way to increase access while minimizing stigma. Some expressed a concurrent concern that medical practitioners receive adequate training in mental health, especially medication management.

Representative responses:

- Integration with primary care is important for prevention and reduce stigma
- Need to acknowledge that real recovery cannot take place without recognizing the "whole person" by seeking full integrations of all services – mental health, physical health, substance abuse, etc.
- Greater emphasis on a seamless integrated system of care the defines mental health broadly as the Surgeon General's report did. Mental health is part of a continuum of health. Hence, it should be included in primary care. Also not that

dually-diagnosed are not only substance abuse but also the developmentally disabled and people with Alzheimer's

Cultural Competence (28)

This theme was manifest both in concerns for inclusion of specific populations and communities and in concerns for how those communities are served. Several people wanted to ensure that people with physical disabilities were included, while others mentioned the need for sensitivity to the client culture. Others noted the rising number of people of color in the state as well as a possible higher rate of mental illness among them. Others expressed concern that while DMH emphasized cultural competence in its vision statement, the first stakeholder meeting was entirely in English.

Representative responses:

- To determine which cultural and linguistic needs should be addressed in each county, I would highly recommend using the California Department of Education's Dataquest
- Cultural competence and acceptance of traditional ethnic values and non-mainstream traditional treatment, beginning with bi-cultural, bilingual providers
- Yes, especially goals regarding the expansion of those programs that have been successful and whose focus is to provide culturally and linguistically competent mental health services. We live in California with such a diverse population. Diversity enriches everyone

Workforce/Training (28)

This theme incorporates all aspects of the mental health workforce, including concerns about lack of support for or too much reliance on peer providers, training for county staff as well as contractors, specific concern that MHSA funding not be spent on increasing current salaries of mental health staff, and training and recruitment issues. Peer providers were also mentioned as an area to include in the statement.

Representative responses:

- Given that there is a crisis in our state with regards to lack of child psychiatrists and general psychiatrists, it is important to focus part of the mission on recruitment and training of children psychiatrists and psychiatrists amongst medical students (i.e., loan forgiveness programs, scholarships, etc.)
- The vision for human resources and for building a diverse, culturally competent workforce in mental health
- Some statement that will indicate support and allows funds to be used to educate all parties of services, conditions, advances, etc.

Outcomes (25)

This theme covers all aspects of evaluation and measurement of outcomes. Respondents expressed concerns that there was not enough mention of these issues.

Several suggested specific measures, while others urged the use of independent audits of outcomes.

Representative responses:

- The comment about alternative outcomes was interesting to me. I am very aware of the pitfalls of using quantitative data that are easy to gather in lieu of richer qualitative information. The topics suggested would lend themselves very well to qualitative study. I would recommend using a combination of quantitative and qualitative methods for the evaluation at state and county levels, using these outcomes: access to safe living environment; meaningful ways to spend time; supportive relationships; ability to get needed assistance; ability to weather crises; and physical health
- Clear statement about commitment to monitor and evaluate current and future changes in system of services, needs, etc.
- Emphasize quality of programs and services, not just the number of programs available

Prevention and Early Intervention (24)

Many people were concerned about the under-emphasis on prevention and early intervention, especially among young children and school-age children, believing that the public schools offer a critical way to reach children and their families who are at high risk but not yet displaying signs of severe emotional disturbance.

Representative responses:

- There is no mention of prevention and early intervention services as a focus of this new vision, especially infant-toddler preschool age prevention services and partnerships with preschool and child care providers and programs
- Put money and emphasis for prevention first. We can never be successful with prevention being an afterthought. Prevention and outreach must come first – if we tie money to severe mental illness we ignore prevention
- Need more emphasis on the prevention aspect of the vision

Process Issues (24)

Several respondents pressed for a shorter version of the vision statement that would be easier to read and more inspiring. Others felt that it was not a visionary statement, but in fact, more "business as usual." Yet others thought it was too ambitious, and others wanted more definitions.

Representative responses:

- The vision is "to transform California's mental health system to a state-of-the art culturally competent system that promotes recovery and wellness"
- Functional, utilitarian – needs inspiration, a poetic concatenation and raising central call to service
- This is an inbred vision statement more creative in language than the MHSA itself

Other (110)
The remainder of responses covered a gamut of issues that respondents felt were not properly or adequately addressed in the draft vision statement. Themes included collaborations especially with criminal justice, substance abuse and other co-occurring disorders, local capacity and control, whether services should all be voluntary or not (most who mentioned it thought they should be, but by no means all). Many respondents were concerned that there was not enough mention of best practices and evidence-based treatment, which many perceived to include seamlessness and transformation of the system. Some were concerned that mobility between counties had not been addressed, while others just said, yes, they agreed. Others named additional stakeholders they thought should be included.

Representative response:
- Vision for an end to a fail first system to a help first system
- Emphasize direction that local plans take are decided locally
- I would try to find a way to engage the people who will be paying the tax of MHSA as stakeholders. There aren't many of them, but they are powerful and could pull the rug out

2. Consider the Principles to be used for establishing the amounts of funds provided to counties for MHSA planning (Attachment E). Are there other criteria or factors that DMH should take in making these funding decisions?

A total of 211 people provided 330 pieces of input. Below is a summary of their responses.

	#
Release Now	63
Release with Plan	31
Plan Okay	56
Plan Not Okay	10
Criteria	56
City Funding	15
Evaluation	11
Other	88
Total	330

Issues

Release January 1 (63)

By a ratio of nearly 2:1, respondents wanted at least some of the funding to be released as soon as possible, to get the planning process underway. A number of different suggestions were made for initial spending: consumer incentives for participation locally or at training conferences, training, and hiring consultants. Concerns were raised about how to monitor this funding, even as they requested the funding.

Representative Responses:

- It makes sense that planning money be put up in order for counties to begin the process. It's unclear to us, how to begin planning without having the requirement
- I think that the money should be used, because that is the only way that you can truly bring the consumers into the planning process. Without the consumers you cannot truly change the system
- There will be those who have great ideas that could help us all but who have no money for attending or organizing meetings. Planning money should be available from now through the planning process
- It doesn't make sense to prohibit counties from spending planning funds until the plans are developed. But other MHSA funds should not be spent until plans are approved. Also, planning funds should not be spent on services. There probably isn't enough funding to do comprehensive planning as it is
- Counties should be able to use money on January 1, 2005 if the dollars are used to increase stakeholder involvement in planning. I also support the suggestion of a discretionary fund to support conferences that bring stakeholders up to speed on MHSA so they can be involved in county planning

Release When Plan Approved (31)

A smaller number of people thought the release of funds should wait until a plan, at least a draft plan, is approved. The reasons ranged from fears of the effects of mismanagement on DMH, money wasted, going against the will of the voters, lack of accountability, poor precedent-setting.

Representative Responses:

- Money should only be spent on approved plan items as stated and passed by voters. If mental health system mismanages, we will lose a previous opportunities to revamp the system. The state voters and special interest are vigilant
- I am concerned that counties would use planning money for other purposes. I favor not releasing the money until after proposals have been evaluated by the State
- Releasing the monies should only come after the expedient review of county plans. Counties may go down the wrong path and waste the money – particularly the counties with little money for planning

Plan Okay (56)
A large proportion of the respondents support the plan for $75,000 base and additional allocation, based on some criteria. Most thought the amount of money was reasonable.

Representative Responses:

- Base amount and theoretical calculation of mental health population via census and statistical and research overlay sounds like a well-thought out and sound methodology
- Base $75,000 per county is okay
- Formula is okay as long as not seen as precedent for allocation of other funds

Plan Not Okay (10)
A much smaller number did not approve of the methods of allocation, for a variety of reasons. Some were concerned about higher cost of living or higher cost of providing services in different locations, based on cultural competency or higher rate of prevalence. Counties were concerned about how it would effect them individually.

Representative Responses:

- Do not support formula – number of mentally ill in a county of affluence can significantly impact services dependent upon service levels – with prevention as a goal, must look at potential mentally ill population to divert. (Large older adult population to decrease in functioning as age)
- I'm concerned that the current system will not provide enough money for some of the counties, in particular, San Francisco, which has a large population of consumers with mental illness, including a large homeless population. Maybe several levels of minimum funding based on population. Perhaps the initial amount of money is too small

Criteria for Allocation (56)
There was much concern expressed about the criteria for the allocation. Concerns were raised again about the high cost of serving a large non-English speaking population, the number of uninsured, the high cost of living in the Bay Area, or serving a large homeless population. Small counties were concerned about the expenses of conducting outreach over large distances or in large rural areas.

Representative Responses:

- I have a question about why it would cost a county with a higher prevalence of mental health needs would need to spend more on planning than a county with a lower prevalence. I believe that the planning money could be divided evenly among all counties, and then use a formula similar to the one proposed to allocate the implementation dollars

- More discussion and additional expert advice is needed in this area. Perhaps an adjustable formula that makes allowances for prevalence, under-represented, underserved and unserved populations
- Was there consumer input in defining standards for prevalence? If not, proposal is flawed
- Having a $75,000 base and higher based on need creates concern for counties like San Francisco, which has a huge homeless population and huge daytime working population. $75,000 would not be enough money to do an adequate plan. Other small counties may not need as much as $75,000

Evaluation (11)

Several people were concerned about the need for evaluation and monitoring of the process, including accountability. They wanted to be sure that money and outcomes could be tracked, ensuring the success of the program.

Representative Responses:

- If funding is released early for planning purposes, strict accountability from counties on how planning money spent
- County's ability to effectively utilize funds and prove outcomes should be tied to future allocations (performance based)
- State clearly how the county will prove that is followed the plan (simple audit by stakeholders)

City Funding (15)

A number of respondents were concerned that Berkeley not be denied access to funding for planning similar to the funding for counties, some noting that its service area is bigger than several counties, has been providing successful programs to high risk consumers for many years and has been an active advocate for the Act. Others noted that both cities with Mental Health Departments should be funded.

Representative Responses:

- The City of Berkeley has its own Mental Health Department and have been pro-active on Prop. 63. Unfortunately, the State of California has said we will not receive planning funds. Alameda County Board of Supervisors already passed a resolution advising against the Governor's California Performance Review recommendation to eliminate Berkeley City Mental Health Department, fold it into Alameda County. This would result in a serious loss of services.
- Allocate planning money to cities with mental health department (3)

Other (88)
A large group of responses did not fit into a neat category shared by a larger group. There was concern about regional cooperation. Others were concerned about the 200% of poverty – some liked it, others thought it arbitrary. Some were concerned that mental illness renders consumers and families in dire straits, likely not to be covered adequately by private insurance, so that everyone with SMI should have access to State DMH funding.

Representative Responses:

- Many children not being served fall in the "working poor" and parents with insurance that do not cover mental health services. I hope they are counted in the 200% of poverty
- The 200% of poverty is no more than an arbitrary model which ignores the unmet needs of the community's unserved and underserved populations
- My only concern is that too much of the available financial resources are lost in an extensive planning process. Counties who utilize resources to identify fresh approaches that are fully embraced by consumers and families should receive funds. County Mental Health does not need to hire internal staff

3. In Workplan Components (Attachment F), DMH tentatively identified six separate components in the MHSA to use as a blueprint for implementation. Do you agree these are the six key components of the Act? If not, what else from the MHSA would you include as an important subject matter area?

Approximately 160 people provided responses to this question, many of them with multiple concerns, for a total of 211 responses. This section is not put into numerical order, but left in the order of the components, with additional concerns or approval listed separately.

Component	#
Local Planning	19
System of Care Services	26
Capital Facilities and Technological Needs	15
Education and Training Programs	28
Prevention and Early Intervention	21
Innovation	13
Agree	39
Outcomes	14
Meeting Process	7
Other	29
Total	211

Component

Local Planning (19)
Most comments about this component centered either on collaboration among counties or ensuring good stakeholder representation, or focusing on prevention.

Representative Responses:

- Can neighboring counties work on their plans together, share expertise and pool resources?
- It's possible that counties will not evenly distribute their efforts and some areas only be addressed minimally while other components be the major focus. This will be influenced by local planning group processes and should be okay
- Explore using, recommending, providing and rewarding counties for using collaborative, cost-effective and efficient planning methods
- Please consider requiring counties to address prevention from the beginning. I believe allowing a plan to come forward without it discards key prevention staff within Mental Health who have worked on Anti-Stigma campaigns, alcohol and other drug prevention, mental health promotion

System of Care Services (26)
Children's system of care was mentioned most often in this component, with concern for young children especially. There was also concern about specific populations not defined by age but by ethnicity, disability or diagnoses. Integration with physical health and substance abuse treatment was also raised here.

Representative Responses:

- Focus on the cost-effectiveness of integrated behavioral health. DMH should consider a carve-out to address payment for two visits per day (to primary care provider and behavioral health provider) in a primary care setting (FQHC). Services provided in other settings (i.e., emergency department) cost four times more
- Children's system of care must include infant/toddler mental health
- Each ethnic population has their own special characteristics and needs that require unique approaches with each system of care

Capital Facilities and Technological Needs (15)
Nearly half of the comments about this component raised concerns about housing. Technology was discussed as a way to help consumers overcome the digital divide.

Representative Responses:

- Capital Facilities should clearly identify that housing needs and plans should be – or must be – articulated in the plan

- Beware of excessive administrative costs that outweigh services. Infrastructure build-up is very necessary yet “kingdoms are often built” and minimal services made available. Other than capital outlay, suggest cap to administrative costs
- Need facility that is a safe house for patients discharged from hospital. Some have no home to go to and will be returning to hospital soon

Education and Training Programs (28)
This component includes all types of training and all manner of target populations, from a general, community (or state) wide media campaign to confront the stigma of mental illness to consumer provider training, to training for law enforcement and school staff.

Representative Responses:

- With due respect to all the other components, I believe a 58 county anti-stigma/anti-discrimination campaign is crucial. By implementing this type of effort, DMH and the counties will be encouraging clients, their families and close friends to talk more openly and address the issues associated with mental illness. People suffering from bi-polar disorder and other mental illnesses need to know that are not alone and that these issues can come out of the dark corners of our communities
- Add the idea of discrimination and prejudice by rewording “reduce the discrimination and stigma” – anti-stigma campaigns train people that people with mental illness deserve stigma, embed the negative, thus helping prejudice to flourish (see cognitive linguistics research on negative media advertising and campaigning)
- Socialization skills should be critical component

Prevention and Early Intervention (21)
Coordination with the schools, especially for children not enrolled in special education, was a key concern. School age children, as well as infants and toddlers, were the primary focus. People at high risk, due to exposure to violence or other trauma, prenatal exposure, or substance abuse, were also of concern.

Representative Responses:

- Prevention and Early Intervention should specifically be integrated into the formal K-12 education system
- Specify preschool-aged children; many people think prevention and early intervention pertain to youth and older children
- Fetal alcohol spectrum disorder (FASD) is very important: many mental health patients have been affected prenatally and go undiagnosed until specifically screened. Our jails and homeless populations are also in this FASD group

Innovation (13)
Most of the comments about innovation were questions about the definition of innovation. Other comments expressed the need to differentiate between already

existing innovations (which may not yet be in California, but which are already out there) and those which will be discovered during the process, as we think outside the box.

Representative Responses:

- Any real, good, new ideas will arise from consumers, not mental health professionals
- Innovation is great – please expand on this, i.e., use of best practices; outcome-based; out of county placements, K-12 linkages

Agree (39)
A large percent of respondents to this question just noted their agreement with the six components.

Representative Responses:

- Those six look good
- I agree that these six components should be used as a blueprint for implementation

Outcomes/Evaluation (14)
As noted in other sections, lack of expressed intent to evaluate and develop outcomes was a concern to a number of respondents. These respondents want to make sure the program shows its benefits and can address its failures.

Representative Responses:

- Workplans should require counties to describe how strategies will achieve outcomes listed in 5840(d) (for example) – workplan should describe how strategies proposed will reduce homelessness, incarceration, etc. Should specifically require description of housing strategies
- Totally missed outcomes. The planning process needs to require activities to accomplish outcomes
- We need a component for outcomes

Meeting Process (7)
Some respondents used this section as an opportunity to raise issues about the operation of the meeting itself, raising concerns about consumer sensitivity.

Representative Responses:

- Too large a group to do more than share concepts and begin to understand the process
- Noise level made it difficult to follow speakers and gain crowd's interest
- Work product expectations might be best shared ahead of time – distribute products expectations (e.g. written feedback on the various components) ahead of the conference. People will come with ideas formulated and not be expected to come up

with concepts on short notice. (Logic would tell you we should be prepared ahead of time anyway, but it's not human nature to do so)
- Facilitated smaller workgroup session might be helpful to move towards expansion of the actual products (I assume there is a workgroup at state level that got this product to the point it is today) – it need to include stakeholder feedback and input

Other (29)

There were a number of responses that did not fit into a specific component, but which were important to record. Some people mentioned the issues with the process of putting the components in effect – the timing, order and priority. Others raised issues of neglect of consumer needs, while others reiterated the need for evidence-based best practices.

Representative Responses:

- Your "7 stages" don't even mention inclusion of clients and family at any time. Number 1 is involve clients by releasing money January 1 so clients can be involved from the beginning. You have stakeholders' input as second stage – no stage for involving clients. As long as you are sitting on the money, no one else can plan, and you can't plan because you don't have the staff, so release the money and hire consumers, it's called grassroots
- Since the consumer stakeholders have not been properly informed and other stakeholders do not want us to be informed and choose to vote down money to become informed, there is clear evidence that we are experiencing unequal power. This is a very competitive process. If you separate us from having the time and money we need to be able to really participate in a meaningful way
- Critical to include cross-disability issues, including accessible formats for hand-outs